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Award Number: W81XWH-06-1-0425

TITLE: Psychosocial and Cultural Barriers to Prostate Cancer Screening: Racial Comparisons

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REPORT DATE: March 2008

TYPE OF REPORT: Annual

PREPARED FOR: U.S. Army Medical Research and Materiel Command
Fort Detrick, Maryland 21702-5012

DISTRIBUTION STATEMENT: Approved for Public Release;
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REPORT DOCUMENTATION PAGE				Form Approved OMB No. 0704-0188	
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1. REPORT DATE 01-03-2008		2. REPORT TYPE Annual		3. DATES COVERED 1 Mar 2007 – 28 Feb 2008	
4. TITLE AND SUBTITLE Psychosocial and Cultural Barriers to Prostate Cancer Screening: Racial Comparisons				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER W81XWH-06-1-0425	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S) Pamela C. Hull, Ph.D. Email: pamhull@tnstate.edu				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Tennessee State University Nashville, TN 37209				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES) U.S. Army Medical Research and Materiel Command Fort Detrick, Maryland 21702-5012				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION / AVAILABILITY STATEMENT Approved for Public Release; Distribution Unlimited					
13. SUPPLEMENTARY NOTES					
14. ABSTRACT The goal of this project is to better understand the psychosocial and cultural factors affecting prostate cancer screening among African American and White men. It is a community-based participatory research project, which involves participation of local community members through a community steering committee. The first phase of the project was a focus group study (Year 1). The second phase used the focus group results to develop a questionnaire instrument (Year 2), and the third phase is to collect survey data on African American and White men (Years 2-3). The fourth phase is to analyze the survey data, and the final phase is to use the results to develop recommendations for interventions to increase informed decision-making about prostate cancer screening among African American and White men (Year 3). The qualitative data provided by the focus groups was used to develop a structured questionnaire with the input of our Community Steering Committee and research consultants. The questionnaire went through several revisions, was pre-tested and the final draft is under review by the local and DOD human subjects review boards. Upon approval, a multi-stage random sample of 400 males will be surveyed.					
15. SUBJECT TERMS Prostate Cancer screening, psychosocial barriers, cultural barriers, health disparity					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			USAMRMC
U	U	U	UU	8	19b. TELEPHONE NUMBER (include area code)

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INTRODUCTION

The goal of this project is to better understand the psychosocial and cultural factors affecting prostate cancer screening among African American and White men. The first phase of the project was a focus group study (Year 1). The second phase was to use the focus group results to develop a questionnaire instrument (Year 2), and the third phase is to collect survey data on a representative sample of African American and White men in Davidson County, Tennessee (Years 2-3). The fourth phase is to analyze the survey data, and the final phase is to use the focus group and survey results to develop recommendations for interventions to increase informed decision-making about prostate cancer screening among African American and White men (Year 3).

BODY

The purpose of this study is to identify psychosocial and cultural barriers to prostate cancer screening among African American and white men. By identifying these barriers, interventions can be designed to increase prostate cancer screening among African American men and reduce racial disparities in prostate cancer outcomes. This study was designed to use a **community based participatory research (CBPR) approach**, with direct participation and input from community members during each phase of the study through the **Community Steering Committee (CSC)**. According to the **Statement of Work (SOW)**, the tasks for Year 2 were to use the focus group results to develop a questionnaire instrument and to begin collection of the survey data. The progress made on the specific actions related to these tasks are reported below.

Task 2. Develop questionnaire instrument

The process of qualitative data analysis and development of the questionnaire, other study materials, and sample design have taken longer than originally anticipated in our project timeline. In particular, implementing the project using a CBPR approach has necessitated us to take slightly longer to develop the questionnaire, since this is the key phase in which community participation can truly impact the study and since the content and quality of the questionnaire are so important to the success of this study. We did not want to force the questionnaire to be developed too hastily and, thus, run the risk of losing the unique contribution that this study will have to offer the scientific literature.

Therefore, we have revised our timeline slightly to extend the time for questionnaire development and postpone the start of survey data collection (Task 3) to April 2008 (Month 26) and collect data through Month 34. This still allows us 9 months to collect the data (as opposed to 12 months in the original timeline). To compensate for this time and to ensure that we finish on schedule, we will hire a larger number of interviewers to collect the data more quickly. Also, the original timeline had projected a very generous amount of time for Tasks 4 & 5 in Year 3 (data analysis and development of recommendations). Rather than spending the last eight months of the project dedicated exclusively to these two tasks, these tasks will overlap with the phase of data collection. In other words, we will start working on these tasks during the data collection phase based on the focus group data and preliminary survey data, then finalize the statistical analyses and intervention recommendations during the last two months of the project based on the final results.

a. Text units from each session will be entered into databases.

Transcriptions of the 10 focus group sessions were completed. The text documents were imported into the NVivo7 qualitative analysis software program.

b. Data will be analyzed using qualitative data software and consensus of statements detected by the CSC and research team

Since this is a CBPR project, the **Community Steering Committee (CSC)** plays an important role in every phase of the project. The CSC is comprised of Dr. Atchison (Chair), Dr. Hull (Principal Investigator), Michelle Reece (Research Associate), two local prostate cancer researchers (from Dr. Jay Fowke from Vanderbilt University and Dr. Flora Ukoli from Meharry Medical College), prostate cancer survivors, church and community leaders, and other interested community members. The CSC includes both African American and white men and women, who are all volunteers.

The text documents were analyzed using the NVivo7 qualitative analysis software program. Key themes and concepts were coded, including relevant psychosocial factors affecting general health care seeking behavior and specifically prostate cancer screening decisions, as well as a focus on the language used by men to discuss these issues. The information was organized into groups of major themes and subthemes, and were presented to the CSC for discussion, interpretation, and feedback. My **mentor, Dr. Baqar Husaini**, also provided valuable guidance and feedback.

c. Analyzed data will then be used to write the year-end report to the funding agency.

This item was mistakenly listed out of order in the original proposal SOW. It should have been listed at the end of Year 2.

Analysis of qualitative data is a time-consuming process. The findings were summarized in a poster for presentation at the DOD IMPaCT Prostate Cancer conference in September 2007. It was also presented at the Meharry-Vanderbilt-TSU Cancer Partnership – Annual Retreat in October 2007. This has been drafted into the first manuscript in progress from this project, which we will complete and submit to a journal for review during Spring 2008. (See copy of poster in Appendix).

d. Consensus of statements (or text units) of focus group participants will be used to determine appropriate areas of questions for the survey questionnaire to be used.

A summary of focus group results by theme were presented to the CSC for discussion, interpretation and feedback, as the first step in developing items for the survey questionnaire. The CSC input and the content of the focus group discussions helped to guide the topic areas for questionnaire items to be developed by the research team.

e. Questionnaire and consent form to be used in survey will be developed (with the help of consultants, Levine, M.D. & Underwood, M.D.) from focus group data and sent to the university's Institutional Review Board for approval.

The focus group findings and CSC input were used to draft sets of possible questionnaire items. The draft questionnaire went through a long process of revisions within the research team based on input from Dr. Husaini, Dr. Atchison, and consultants who are experts on cancer screening (Dr. Robert Levine from Meharry Medical College) and survey design and questionnaire development (Dr. Tony Brown from Vanderbilt University – Sociology, and Mr. Marie Hammond from TSU – Psychology).

In addition, the draft questionnaires were presented to the CSC at three separate meetings, which made numerous suggestions for additions, deletions, and modifications, particularly in terms of wording changes to make the questions more understandable to the average person, making sure

that we did not leave out important information, and reminding us to keep the questionnaire as short and easy-flowing as possible. During this process, drafts of the questionnaire were also pre-tested on office staff, students, and men in the local community in order to work out issues with question wording and flow of questions.

In addition to the new questions that were developed based on the focus groups, numerous existing previously-validated instruments were reviewed to consider including them to measure possible covariate variables. Several instruments were chosen to include in the questionnaire, such as self-efficacy, depressive symptoms, health literacy, religiosity, discrimination, etc.

To accompany the questionnaire, we developed flash cards for the interviewer and a respondent booklet with sets of answer choices, to ease the interview process. We also developed the recruitment flyer and the informed consent form, both of which were modified based on input from the CSC on optimal wording and presentation. We created field tracking forms to document contacts with selected households and an interviewer protocol for the questionnaire. The field tracking database and the questionnaire database have been set up for data entry and to securely handle participant information and questionnaire data.

Task 3. Collect survey data

Some of the activities for this task have been done or are in process. This task will continue in Year 3.

a. Interviewers will be hired and trained in survey methods.

We are currently in the process of hiring and training survey interviewers. They are being trained in the protection of human subjects, the recruitment protocol for approaching households, field documentation of household contacts, the informed consent process, the questionnaire protocol, and interviewing techniques.

b. Using computer randomizing software program, possible participants will be chosen from the same census tracts as the ones used for focus groups.

The focus groups were not sampled from census tracts. Instead, the PI worked with consultant, Dr. Tony Brown, to develop the sampling design for the survey. Dr. Brown was trained at the University of Michigan Survey Research Center and has experience working with the Detroit Area Study. Dr. Brown has advised us on various options for generating a representative sample of White and African American men in Nashville ages 40-70. After exploring the feasibility and efficiency of these various options, we decided to use a multi-stage, stratified cluster sample. The detail of the sampling strategies have been detailed in study protocol submitted to the IRB.

c. Contact selected households by mail and then in person, determine eligibility and invite participation in the study.

The study protocol was submitted to the local IRB and DOD human subjects protection committee for review. We received the initial review from each committee, and the DOD committee requested some minor clarifications. These are being completed to resubmit to both committees during the first week of April 2008. Recruitment and data collection will commence immediately upon receipt of these approvals (expected by mid-April 2008).

Problems Encountered

As explained above, the process of qualitative data analysis and development of the questionnaire,

other study materials, and sample design have taken longer than originally anticipated in our project timeline. This necessitated us to readjust our timeline. We feel that the new timeline is realistic and will enable us to complete the remaining project tasks during Year 3.

KEY RESEARCH ACCOMPLISHMENTS

- Completed transcription of focus groups
- Completed qualitative analysis of focus groups
- Used focus group findings to develop new questionnaire items
- Collaborated with Community Steering Committee (CSC) to gain input on content of questionnaire and survey recruitment strategies
- Worked with expert consultants to refine questionnaire items and format
- Worked with expert consultant to develop sampling design for survey
- Developed interviewer flash cards, respondent booklet, recruitment flyer, informed consent form, field tracking forms, and databases.
- Prepared interviewer training materials
- Started recruiting, hiring and training field interviewers
- Submitted purchasing requests to buy participant incentives (grocery gift cards) and other materials need for data collection.
- Prepared survey protocol for human subjects protection review.
- Submitted to survey protocol to local IRB and DOD human subjects committee.
- Received approval from local IRB and initial review from DOD human subjects committee.
- Re-submitting protocol with requested clarifications to both committees for final approval.
- Submitted annual progress report

REPORTABLE OUTCOMES:

- September 2007: Presented poster of focus group findings at DOD IMPaCT prostate cancer conference in Atlanta, GA
- October 2007: Presented poster of focus group findings at Meharry-Vanderbilt-TSU Cancer Partnership – Annual Retreat in Nashville, TN
- Drafted working manuscript of focus group findings, which is being revised for submission to a journal in spring 2008
- February 2008: submitted abstract to American Public Health Association to report focus group findings at the November 2008 meeting

CONCLUSION:

Summary

Through a participatory process with our CSC, we have used the qualitative focus group data to develop innovative questionnaire items regarding psychosocial and cultural barriers to prostate cancer screening. While this process took longer than originally anticipated, this participatory process has enriched the quality of the questionnaire and promises to provide useful information for reducing racial disparities in prostate cancer. We are prepared to start survey data collection as soon as IRB approvals are received, and will collect all survey data by month 34, in time to complete analyses and recommendations by month 36 (end of project period).

Significance

Prostate cancer is the most common type of cancer found among men in the U.S., besides skin cancer. Prostate cancer is the third leading cause of cancer death in men, after lung cancer and colorectal cancer, although many older men with prostate cancer have relatively good chances of surviving this cancer, especially when it is detected early. However, only about half of men age 50 and older are screened for prostate cancer each year.

While prostate cancer is a health concern for all men, African American men are more likely to get prostate cancer than white men, and they are more likely to die from prostate cancer and at younger ages. The United States average prostate cancer prevalence rates for 1992–2002 are over 1.6 times higher for African American men than for white men. Similarly, during the same period (1992–2002) there was a 2.4 times higher prostate cancer death rate for African American men as compared to white men (73.7 and 31.2 per 100,000, respectively). Yet, African-American men are also less likely to get screened for prostate cancer using a PSA blood test than white men.

We know that lack of health insurance and financial limitations can prevent some men from getting screened for prostate cancer. However, there also appear to be other barriers that are not as well understood. These could include various psychological, social and cultural factors. If we understood these factors better, we could design more effective programs to motivate more men to talk to their doctors about screening options and to get screened regularly. For example, if African American men lack belief that early detection of the disease will make a difference in outcome for prostate cancer, as some studies suggest, then a fatalistic attitude can develop and discourage screening behavior. Belief in one's ability to obtain screening and support from family and friends has been found to be a positive influence on screening and treatment behaviors for many health conditions. We know that in general, cultural sensitivities related to personal or historical experiences with the medical community play a role in African American men's attitude toward preventive health screenings. It is important to know specifically what barriers are most salient to African American men and the differences in perceived barriers compared with their White counterparts.

REFERENCES

NONE

APPENDIX

NONE